

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=63-022632

DO NOT WRITE
ON THIS STUD

AMENDED

Registration District No. 917 Primary Registration District No. 500 Registrar's No. 1685 STATE FILE NUMBER

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY St. Louis | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) Fenton | | Length of stay in 1b 23 Mo. | c. CITY OR TOWN Valley Park Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Fieser Nursing Home | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 800 Vest. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|---|----------------------------------|---|---|---|---|
| 3. NAME OF DECEASED (Type or print) First Ethel Middle Mary Last King | | | 4. DATE OF DEATH Month 5 Day 24 Year 63 | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 5/17/1885 | 9. AGE (last birthday) 78 | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) Violet Hill Ark. | |
| 12. CITIZEN OF WHAT COUNTRY U.S.A. | | | | | |

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|---|--|---|--|--|--|
| 13a. FATHER'S NAME Samuel Houston Billingsley | | 13b. MOTHER'S MAIDEN NAME Emma E. Nicks | | 14. NAME OF HUSBAND OR WIFE | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Nedra May Martin Address as above | |

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest | | INTERVAL BETWEEN ONSET AND DEATH 2 min. |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Hypertensive Cardiovascular Disease | | 15 yr. |
| DUE TO (c) | | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, but not related to the terminal disease condition given in PART I (a) Cerebral thrombosis & hemiparesis; Generalized Arteriosclerosis | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |
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| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
| 20c. TIME OF INJURY Hour 1:45 a.m. p.m. | Month, Day, Year | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION | COUNTY STATE |

21. I attended the deceased from Sept 26 1960 to May 24 1963 and last saw her alive on May 24 1963
Death occurred at 1:45 P on the date stated above, and to the best of my knowledge, from the causes stated.

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|---|---|------------------------------------|
| 22a. SIGNATURE W.B. Sydney M.D. (Degree or title) | 22b. ADDRESS 806 Mercier St. N. Valley Park Mo. | 22c. DATE SIGNED 5-25-63 |
|---|---|------------------------------------|

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|---|-------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 5/27/1963 | 23c. NAME OF CEMETERY OR CREMATORY Riverside Cemetery | 23d. LOCATION (City, town, or county) (State) Mammoth Springs Ark. |
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| 24. FUNERAL DIRECTOR Leo H. Fieser ADDRESS Fenton Mo. | 25. DATE RECD. BY LOCAL REG. 5-25-63 | 26. REGISTRAR'S SIGNATURE John B. Murphy M.D. |
|--|--|---|

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

DATE AMENDED

VS 300
Rev. 4/59

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

James D. Mahan

Licensed Embalmer No. 1326

P. O. Address

Reb. & Me

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.